



January 25, 2016

Senator Johnny Isakson  
Co-Chair of Chronic Care Working Group  
131 Russell Building  
Washington, DC 20510

Senator Mark Warner  
Co-Chair of Chronic Care Working Group  
475 Russell Building  
Washington, DC 20510

Dear Senator Isakson and Senator Warner,

The US Oncology Network, which represents over 10,000 oncology physicians, nurses, clinicians and cancer care specialists nationwide, appreciates the opportunity to provide feedback on the Chronic Care Working Group Policy Options Document. As a provider treating one of the most common and costly chronic medical conditions today, I applaud your efforts to further chronic care coordination and improve the health care system for our nation's seniors.

I am a physician and leader in The US Oncology Network. We are one of the nation's largest and most innovative networks of community-based oncology physicians, treating more than 750,000 cancer patients annually in more than 450 locations across 40 states. The Network unites over 1,000 like-minded physicians around a common vision of expanding patient access to the highest quality, most cost-effective integrated cancer care to help patients fight cancer, and win.

#### **Developing Quality Measures for Chronic Conditions**

The US Oncology Network appreciates the Working Group's interest in developing quality measures focused on health care outcomes for individuals with chronic disease, specifically as it pertains to end-of-life care. As oncology care providers, advance care planning (ACP) discussions are a necessary part of the management and care plan for some patients. The Network has been at the forefront of this issue through the *My Choices, My Wishes*<sup>SM</sup> program which was launched in 2013 to support providers in delivering values-based ACP.

*My Choices, My Wishes*<sup>SM</sup> assists patients with advanced cancer to:

- Identify personal values and goals for care;
- Communicate effectively with clinicians and loved ones about what is important in their care (and what is not); and
- Develop a personal definition of "living well" within the context of serious illness.

*My Choices, My Wishes*<sup>SM</sup> supports full documentation of these discussions within an electronic medical record system, including formal advance directive documents and health care proxy designations that may evolve through the discussion process. Ultimately, practices are finding that higher quality end-of-life care can be realized through improved patient and family preparation. More important, patients and families are positioned better to experience their final weeks in ways that are consistent with their personal values.

Today, *My Choices, My Wishes*<sup>SM</sup> implementation has expanded to 64 sites of service within The US Oncology Network, reaching more than 5,000 cancer patients. Its integration within the patient's plan of care is important and requires a focused effort on the part of practice staff to assure that patients

wanting to have these discussions are enabled to do so. Best practices have evolved to include a multi-disciplinary approach utilizing trained physician, advanced practice provider, and social worker skill sets.

The Centers for Medicare & Medicaid Services (CMS) has also recognized the value that ACP discussions have for patients, their families and their care team. The CY 2016 Medicare Physician Fee Schedule included a proposal to establish separate payment for ACP services provided to Medicare beneficiaries by physicians and other qualified health professionals.

While these are important steps forward in furthering ACP services, there is more to be done to improve end-of-life care coordination. ACP services add additional costs through increased training, infrastructure requirements and use of staff members on the patient's health care team. In The US Oncology Network today, nearly half of all ACP services are performed by social workers. While it is typical for a physician to initiate a discussion with a patient about long-term treatment options and planning, patient-centered counseling that allows patients to make the best, informed decisions about their care and assistance with the preparation of advance directive documents usually occurs with a mid-level provider or social worker. The US Oncology Network supports allowing all members of the health care team, including clinical social workers, to participate and be reimbursed for ACP services.

The development of quality measures for ACP services should include significant coordination and input with stakeholder groups to ensure any new measures complement existing oncology quality measures, avoid duplicative reporting and do not increase administrative burdens. Given The US Oncology Network's experience in creating and implementing the *My Choices, My Wishes*<sup>SM</sup> program, we are happy to serve as a resource in any further discussions or proposals advancing end-of-life care coordination.

### **Increasing Transparency at the Center for Medicare & Medicaid Innovation**

In February 2015, CMS announced the launch of the Oncology Care Model (OCM), an episode-based payment model aimed at improving care coordination, appropriateness of care, and access to care for beneficiaries undergoing chemotherapy. Participants in the OCM are expected to rely on the most current medical evidence and shared decision-making with the patient to determine whether a beneficiary should receive chemotherapy treatment. CMS will incentivize participating physician practices to effectively address the complex care needs of chemotherapy patients, and heighten the focus on furnishing services that specifically improve the patient's health outcomes.

13 US Oncology Network practices with 787 providers have applied to participate in the OCM which is set to launch on July 1, 2016. These practices have made a voluntary decision to participate in the pilot program with hopes of improving outcomes for chemotherapy patients while realizing savings for the healthcare system.

The creation of the OCM was a multi-faceted process, spanning several years and engaging numerous stakeholders. Therefore, any proposed changes to the OCM should be subject to the rulemaking process allowing stakeholders to review, vet and comment on any changes. As CMS continues to move toward payment models linked to quality or value, it is imperative to ensure transparency and allow for stakeholder input into all payment and delivery reform efforts.

## Preserving Access to Cost-Effective, Community-Based Cancer Care

Cancer continues to be one of our nation's most costly and prevalent chronic conditions. Today there are over 14 million Americans with a history of cancer and more than eight million of those people are currently over the age of 65, resulting in approximately half of all cancer spending going towards care for Medicare beneficiaries<sup>1</sup>. The National Cancer Institute states that the U.S. spent over \$125 billion on cancer care in 2010 and projects that cancer care costs will increase to \$156 billion by 2020<sup>2</sup>.

Exacerbating cancer's impact on the US health care system is the disparity in cost for cancer care based on the site of service. The cost of providing cancer care in a hospital outpatient department is significantly higher than the *exact same care* delivered at a community cancer clinic: charging approximately 126 percent higher costs for administering common cancer drugs and 100 percent higher costs for drug infusion services overall.

Treating cancer patients in community-based cancer clinics as opposed to the outpatient hospital setting results in significantly lower costs to both patients and the Medicare program. Total Medicare spending on patients receiving chemotherapy in the community clinic is 14.2 percent lower than the hospital outpatient department (HOPD), which equals \$623 million in Medicare savings per year.<sup>3</sup> In addition, an April 2012 study released by Avalere Health<sup>4</sup> found that chemotherapy provided in a physician's office costs, on average, 24 percent less than chemotherapy provided in the hospital outpatient setting. Patient co-payments are approximately 10 percent lower in the clinic, equaling more than \$650 in savings for each Medicare beneficiary fighting cancer per year. Additionally, the average out-of-pocket patient cost for commonly used cancer drugs is \$134 less per dose if received in an oncologist's office.<sup>5</sup>

These costs add up. Between 2009 and 2012, Medicare beneficiaries paid \$4.05 million more in out-of-pocket costs because of the higher patient co-payment due to the HOPD for chemotherapy services that could have been performed at a community cancer practice for a fraction of the cost.<sup>6</sup>

Unfortunately, over the last decade there has been a significant shift in the delivery of certain services from the community to the hospital outpatient setting, resulting in increased costs to the Medicare program and its beneficiaries. A December 2015 report released by the GAO examined trends in vertical consolidation between hospitals and physicians and found that the number of vertically consolidated hospitals increased from about 1,400 to 1,700, while the number of vertically consolidated physicians doubled from about 96,000 to 182,000. GAO found that in 2013, the total Medicare payment rate for a mid-level E/M office visit for an established patient was \$51 higher when the service was performed in an HOPD instead of a freestanding physician's office.<sup>7</sup>

Fortunately, Congress has recognized the negative consequences this policy has on patients, taxpayers and businesses and included a site-neutral payment provision in the recent Bipartisan Budget Act. The measure includes a provision aligning payments for all newly acquired provider-based off campus

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<sup>1</sup> The National Cancer Institute <http://www.cancer.gov/about-cancer/what-is-cancer/statistics>

<sup>2</sup> The National Cancer Institute <http://www.cancer.gov/about-cancer/what-is-cancer/statistics>

<sup>3</sup> Milliman Client Report: Site of Service Cost Differences for Medicare Patients Receiving Chemotherapy. October 19, 2011. Kate Fitch and Bruce Pyenson. <http://publications.milliman.com/publications/health-published/pdfs/site-of-service-cost-differences.pdf>

<sup>4</sup> Avalere Client Report: Total Cost of Cancer Care By Site of Service. March 2012. [http://www.avalerehealth.net/news/2012-04-03\\_COA/Cost\\_of\\_Care.pdf](http://www.avalerehealth.net/news/2012-04-03_COA/Cost_of_Care.pdf)

<sup>5</sup> Milliman, "Site of Service Cost Differences for Medicare Patients Receiving Chemotherapy," October 2011.

<sup>6</sup> Berkeley Research Group, "Impact on Medicare Payments of Shift in Site of Care for Chemotherapy Administration," June 2014.

<sup>7</sup> GAO, "Medicare: Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform," December 2015.

HOPDs with payments to physician practices paid under either the Ambulatory Surgical Center (ASC PPS) or the Medicare PFS. This policy is expected to save Medicare approximately \$9 billion over 10 years.

While the provision in the Bipartisan Budget Deal is an important first step in instituting payment parity across sites of service, HOPDs billing Medicare prior to November 2, 2015 are able to continue billing at the much higher OPFS rate for the same services resulting in increased costs for those Medicare patients, Medicare, payers and employers.

As the Chronic Care Working Group looks for ways to identify savings, we encourage you to consider neutralizing payments across sites of service for all outpatient services. Medicare should be paying the same fee for the same service regardless of where it is performed. This policy reform has the bipartisan support of lawmakers, the Medicare Payment Advisory Commission, the Government Accountability Organization and a broad group of healthcare stakeholders including providers, insurers and consumers.

On behalf of the nation's leading community cancer care providers, we appreciate the opportunity to share our ideas and look forward to working with you to improve care coordination for patients with chronic conditions. Feel free to use us as a resource throughout this process as we are happy to provide any additional insight.

Sincerely,

A handwritten signature in black ink, reading "Lucy Langer". The signature is fluid and cursive, with the first name "Lucy" and last name "Langer" clearly distinguishable.

Dr. Lucy Langer  
Chair, National Policy Board  
The US Oncology Network